

S. No. 2
M-5-43
7. 5-17-39
X 36671

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8645

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5903 Cates Ave.
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME J. Edward McKeown

3. (b) If veteran, name war No

3. (c) Social Security No. 489-22-1266

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7th
year 1946 hour 9:00 minute..... P. M.

21. I hereby certify that I attended the deceased from Sept. 12, 1946, to Oct. 7, 1946; that I last saw him alive on Oct. 7, 1946; and that death occurred on the date and hour stated above.

4. Sex: Male 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary Ellen

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased July 13, 1876
(Month) (Day) (Year)

Immediate cause of death Cerebral Arterio sclerosis Duration 1 month

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>2</u>	<u>24</u> hr. min.

Due to General Arterio sclerosis

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Shapleigh Hardware Co.

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

MOTHER, FATHER

12. Name John McKeown

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Winifred Farrell

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Loretta McKeown

(b) Address 5903 Cates

17. (a) Burial (b) Date thereof 10 - 9 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director John D. Stuart

(b) Address 225 N. 1st St. St. Louis

19. (a) OCT 8 1946 (b) J. J. Oradeck
(Date received local Registrar) (Registrar's signature)

(Specify type of place) While at work?..... (c) Means of injury.....

23. Signature Hiram L. Hyslop (M. D. or other) M.D.
Address 3722 Washington Blvd. Date signed 10/8/46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. Allen Davis Jr.

Licensed Embalmer No. 4053

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.